

4. Asthenic Paralysis and Autopsy Record. (E. FLATAU) GOLDFLAM.

1. *Pathological Anatomy of Tetany*.—An autopsy report on a case of tetany, associated with narrowing of the pylorus, which was due to an overgrowth of connective tissue, probably the result of a gumma in the stage of final sclerosis. The voluntary muscle tissue under the microscope, showed an increase in the sarcolemma nuclei, arranged in places in chain-like formation. Degeneration of the anterior and posterior roots, with disappearance of the myelin sheaths, swelling and tortuosity of the axis cylinders, etc., was found. By the Marchi method small dots of degeneration were found irregularly scattered through the spinal cord. Diffuse chromatolysis with displacement of the nucleus was found in some of the spinal cord cells. These cell changes are the result of an intoxication and are not to be considered as specific for tetany.

2. *A New Symptom of Chronic Lead Poisoning*.—A case of chronic lead intoxication in an author, with symptoms resembling tetany. The patient had had lead colic, with the blue line on the gums, and developed a chronic progressive disease of the muscles manifested by tetanic contraction of varying muscle groups, excited by slight irritation, quick movements, etc., and at times developing spontaneously. The tetanic spasm was decidedly painful. Chvostek's symptom was present, but the spasm did not at any time affect the facial muscles. Sensation was normal. The diagnosis was doubtful, but was either a tetany or a myoclonia, or a symptom complex between these two conditions.

3. *Magenta Red as a Stain for Nervous Tissues*.—Zosia calls attention to the value of a 1 per cent. solution of magenta red as a counter-stain for "Pal" preparations, etc.

4. To be continued.

*Neurologisches Centralblatt.*

(1902. March 16, No. 6.)

1. A Case of Acute Disseminated Myelitis, or Encephalo-myelitis following CO Poisoning. A. PANSKI.

2. A Further Contribution to Asthenic Paralysis. S. GOLDFLAM AND E. FLATAU.

1. *Acute Disseminated Myelitis*.—A case is reported presenting the following symptoms: a spastic, not atrophic, paralysis of the lower extremities; incontinence of urine and feces; vasomotor and trophic disturbances such as a pemphigus eruption, bed sores, etc., prolonged somnolence lasting over days; confusion; slowed, indistinct speech; amnesia, etc. He therefore makes the diagnosis of acute encephalo-myelitis. The case differs from those already on record, in the presence of the cerebral symptoms. Very few of the above symptoms could be detected after two months. A very complete bibliography is added to this article.

McCARTHY (Philadelphia).

2. To be continued.

*Journal de Neurologie*

(1902. January 5, 20; February 5. Nos. 1, 2 and 3.)

1. Contribution to Medullary Localization. PARHON AND GOLDSTEIN

2. Conjugal Cord Affections. GLORIEUX.

3. The Fascia Lata Reflex. J. CROCO.

4. The Post-anesthetic Paralyzes. D. DE BUCK.

5. A Case of Vertebral Cancer. RAYMOND.

1. *A Contribution to Medullary Localization* (Continued from No. 25, December 20, 1901).—Drs. Parhon and Goldstein discuss at length

their theories and results of some of the recent investigations. As the nature of the subject will not bear condensation, the reader is referred to the original.

2. *Two Cases of Conjugal Cord Affections*.—The author refers to the works of German authors, especially Mendel, who report cases of general paralysis of the insane, occurring in man and wife. In the majority of these cases a history of previous syphilis was established in one or both. Strümpell in 1888 recorded a case of conjugal tabes both giving evidences of lues. Talon in 1898 collected 16 cases of locomotor ataxia in married couples. Dr. Glorieux's first pair presented unmistakable symptoms of locomotor ataxia. In neither was the slightest history or indication of syphilis forthcoming. The wife had given birth to 15 children, 10 dying in early life, one of convulsions, the others of fevers.

Of the second pair the husband had tabes of the amaurotic type, and the wife a spastic paresis of the right leg, with slight vesical symptoms; no sensory disturbances; Babinski phenomenon on both sides. The wife's paralysis had developed gradually, following an operation for removal of a uterine tumor. She had had one miscarriage and three still-born children previous to this. Here the writer likewise excluded syphilis, admitting, however, that the large mortality of the offspring in the first case, and the still-births in the second, would be accepted by many. Clinicians, he says, are too prone to accept vague and uncertain evidence of this character as bearing on an antecedent syphilis.

3. *The Fascia Lata Reflex*.—Reference is made to Brissaud's original communication on this subject in 1895. Brissaud obtained by gentle plantar stimulation an isolated contraction of the *tensor vaginae femoris*; in some cases a contraction of the adductors, or the adductors and extensors of the thigh occurred as well. In a few cases contraction of the adductors of the opposite thigh was the only response.

As the plantar innervation corresponds to the second and third sacral segments, and the superior gluteal nerve which supplies the tensor of the fascia lata originates in the third and fourth lumbar segments, Brissaud assumed that the reflex arc had an extensive intramedullary course.

On the other hand Ganault, in his thesis published in 1898, believes that the internal saphenous nerve, which inosculates with the plantar nerves, carries the impulse to the spinal cord, and as this nerve is represented in the second, third and fourth lumbar segments, the intramedullary course of the arc would be materially shortened. Dr. Crocq follows with three observations, in which the fascia lata reflex was present under peculiar circumstances. (I) A man with paraplegia probably due to an alcoholic neuritis; with loss of the tendon and skin reflexes; no sensory disturbances. The sole response to plantar excitation was an isolated contraction of the *tensor vaginae femoris*. (II) A man aged 55, who since his fifth year had carried the remains of a right-sided hemiplegia: exaggeration of the tendon reflexes, ankle-clonus and Babinski, presented symptoms of cord compression in the lumbar region: paraplegia, loss of pain and temperature sense below the umbilicus, maintenance of the sphincters and decubitus. The patellar and Achilles jerks were of normal range on the right side, very feeble on the left, cremaster and abdominal reflexes abolished, Babinski present on both sides as well as a very energetic contraction of the tensor of the fascia lata. (III) A mason who, from an injury to the cord at the age of 22, was left with a permanent bilateral foot drop, at the age of 52 was seized with pains and weakness in the lower extremities; sensation undisturbed; knee-jerks abolished, Achilles jerks exaggerated, plantar and

cremasteric reflexes feeble. The reflex of the fascia lata exaggerated on both sides. His symptoms, which were due to alcohol, improved under treatment, but then persisted: loss of knee-jerks, exaggeration of the Achilles jerks lends support to the theory of Brissaud that the sciatic and not the internal saphenous conveys the centripetal impulses.

4. *The Post-anesthetic Paralysis*.—Dr. D. de Buck quotes some of the conclusions reached by Bastit and de Moret in their extensive monographs dealing with this subject. That the amount of chloroform administered bears no relation to the production of the paralysis. Hysteria and cachexia are predisposing factors. Cardiac and arterio-sclerotic affections play a rôle (embolism and thrombosis). These paralyzes are especially frequent in women, not infrequently following operations on the genital organs. A reflex paralysis from the operative trauma offers the only explanation in some cases. Various types of paralyzes occur, as monoplegia, hemiplegia, disseminated and cranial. The symptoms are usually not severe and disappear quickly, suggesting a remediable cell or fiber change (*lésions necrobiotiques*). Dr. de Buck follows with three personal observations.

*Case I.*—A woman aged 56 years underwent curettage for an inoperable carcinoma of the uterus. Chloroform narcosis of fifteen minutes' duration. Regained consciousness with a paralysis of the right arm with tingling. No objective sensory disturbances, no electrical changes; recovery in two months.

*Case II.*—A woman aged 40 was operated for uterine fibroids. An abdominal hysterectomy was performed, in the Trendelenburg position, chloroform anesthesia lasting an hour. After the effects of the chloroform had worn off, there remained a paresis of the left arm with tingling, exaggerated reflexes; no objective sensory disturbances; no electrical changes.

*Case III.*—A woman aged 44 was 15 minutes under chloroform for a curettement. Was very anemic. The next day developed a right-sided hemiplegia with motor aphasia; ankle-clonus; Babinski's phenomenon. Pains and hyperesthesia on the right side. Total recovery in three weeks.

The author excludes all possibility of trauma or pressure in the above cases.

5. *A Case of Vertebral Cancer*.—Prof. Raymond reports a case of a woman aged thirty-seven years, shortly after an extirpation of the left breast for carcinoma, was seized with dull pains in the back. These pains soon became sharp and lightning-like, agonizing in their intensity, and having an intercostal irradiation. At the same time there developed painful cramps in the lower extremities, causing forced flexion of the legs. Sitting or stooping aggravated back symptoms. Later the lower extremities became numb and progressively weaker, the lancinating pains abating in their intensity. A few months later was admitted to Prof. Raymond's service in the Salpêtrière in the following condition:—complete paralysis of the lower extremities, the abdominal, intercostal and sacro-lumbar muscles. The breathing was diaphragmatic. Knee-jerks present; Achilles-jerks absent, as were also the plantar reflexes. A dissociated anesthesia extending to the umbilicus. Tactile sensibility preserved but obtunded. Deep sensibility undisturbed. There was dysuria, obstinate constipation and tachycardia. Lateral movements of the head caused severe pain; there were frequent sub-occipital headaches. Prof. Raymond refers the symptoms to a carcinoma metastasis, implicating the upper portion of the dorsal segment of the cord, and involving chiefly its antero-lateral portion, including the gray matter. He offers the following division.

I. Latent carcinoma of the vertebra (involving the body).  
 II. Carcinoma of the vertebra causing compression of the cord; posterior root symptoms absent, or of trifling significance.

III. Carcinoma of the vertebra causing persistent agonizing pains. These cases are often produced by the malignant growth, forcing its way through the intervertebral foramina from the thoracic or abdominal cavities. The spinal deformity in carcinoma is usually a curvature *grande courbure* in contradistinction to the gibbus of Pott's disease.

The author, in conclusion, refers to the views, old and new, which have been held in regard to the cord changes produced by compression. The ischemic softening of Tripiér. The transverse myelitis of Charcot, with secondary degenerations. The frank inflammation of Leyden. The stasis of lymph and cerebrospinal fluid of Schtscherbach and Rosenbach. The local edema which may be mechanical or inflammatory or both, producing a softening terminating in sclerosis as suggested by Schumanns, who admits that myelitis may develop by a direct extension from the neoplasm. In these cases of malignant disease of the spine with severe pains, Prof. Raymond believes a palliative operation has ample justification, notwithstanding the absolutely fatal prognosis.

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*Revue Neurologique.*

(1902. Vol. 10, No. 3, February 15.)

1. Two Histological Aspects of Tuberculous Ventricular Ependymitis. D. ANGLADE.
2. Destruction of the Sphenoidal Pole and of the Hippocampal Region in Two Hemispheres. BOUCHARD.
3. A Case of Hematic Cyst in the Brain. A. VIGOROUX AND M. LAIGNEL-LAVASTINE.

1. *Tuberculous Ventricular Ependymitis.*—The author says that few studies are more instructive than those of the nervous systems of patients subject to tuberculosis in any of its forms. To look at a brain tainted with meningitis or tuberculosis is interesting; but much more profit comes from study of the whole nervous system of tuberculous patients who, during life, have shown no marked nervous or cerebral symptoms. It is known concerning tuberculosis of nerve centers that it is there manifested in the form of tubercles or of tuberculous liquid; the bacillus reaches the centers through the meningeal vessels, and in the lumen around these vessels tuberculous granulations are developed which may affect vascular obliteration and consequent softening of surrounding regions. Aside from the direct lesions caused by the bacillus are those in which it takes part only indirectly, as sclerosis of the medulla and brain. It has been shown that the tubercle causes, in the medulla, systematic fascicular sclerosis, hyperplasias followed by necrosis and formation of cavities analogous to those of syringomyelia; and the lesions of the syringomyelia are associated with those of tuberculous meningitis. Tuberculous poisons in the brain stimulate analogous neurological reactions, and to some of these attention is called by the author.

2. *Destruction of the Sphenoidal Pole and the Hippocampal Regions.*—At the autopsy of a patient who, during life, had shown mental trouble and who succumbed to meningeal hemorrhage, destruction of the temporal pole and the hippocampal region in both hemispheres was assigned as the cause. The alterations seemed to evidence loss of substance without traces of irritation, and may throw some light on questions of the relative functions of the hippocampal region. The patient was a soldier when he began to show mental trouble, especially weak-